NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

BPMC No. 19-038

IN THE MATTER
OF
EUGENE JAGELLA, M.D.

COMMISSIONER'S ORDER OF SUMMARY ACTION

TO: EUGENE JAGELLA, M.D.
[redacted]

The undersigned, Howard A. Zucker, M.D., J.D., Commissioner of Health, pursuant to N.Y. Public Health Law §230, upon the recommendation of a Committee on Professional Medical Conduct of the State Board for Professional Medical Conduct, has determined that the duly authorized professional disciplinary agency of another jurisdiction, the Commonwealth of Massachusetts has made a finding substantially equivalent to a finding that the practice of medicine by EUGENE JAGELLA, M.D, license number 177838. (the Respondent) in that jurisdiction constitutes an imminent danger to the health of its people, as is more fully set forth in the January 25, 2018 Order of Temporary Suspension and supporting documents, of the Massachusetts Board of Registration in Medicine (henceforth: "predicate action"), attached hereto as Appendix "A" and made a part hereof.

It is therefore:

ORDERED, pursuant to N.Y. Public Health Law §230(12)(b), that effective immediately, Respondent shall not practice medicine in the State of New York, or practice in any setting under the authority of Respondent's New York license.

Any practice of medicine in violation of this Order shall constitute Professional Misconduct within the meaning of N.Y. Educ. Law §6530(29) and may constitute unauthorized medical practice, a Felony defined by N.Y. Educ. Law §6512.

This Order shall remain in effect until the final conclusion of a hearing which shall commence within thirty days after the final conclusion of the disciplinary proceeding in the predicate action. The hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230, and N.Y. State Admin. Proc. Act §§301-307 and 401. The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on a date and at a location to be set forth in a written Notice of Hearing or Notice of Referral Proceeding to be provided to the Respondent after the final conclusion of the proceeding in the predicate action. Said written Notice may be provided in person, by mail, or by other means. If Respondent wishes to be provided said written notice at an address other than that set forth above, Respondent shall so notify, in writing, both the attorney whose name is set forth in this Order, and the Director of the Office of Professional Medical Conduct, at the addresses set forth below.

Respondent shall notify the Director of the Office of Professional Medical Conduct, New York State Department of Health, Riverview Center, 150 Broadway, Suite 355, Albany, New York 12204-2719 via Certified Mail, Return Receipt Requested, of the final conclusion of the proceeding in the predicate action, immediately upon such conclusion.

THE NEW YORK PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO OTHER SANCTIONS SET FORTH IN NEW YORK PUBLIC HEALTH LAW §230-a. YOU ARE URGED

TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: February 27th, 2019
Albany, New York

[redacted]
Howard A. Zucker, M.D., J.D.
Commissioner of Health
New York State Department of Health

Inquiries should be directed to:

Ian H. Silverman
Associate Counsel
N.Y.S. Department of Health
Division of Legal Affairs

APPENDIX "A"

COMMONWEALTH OF MASSACHUSETTS

Middlesex, SS.

Board of Registration in Medicine

Adjudicatory Case No. 2018-006

In the Matter of

EUGENE C. JAGELLA, M.D.

ORDER OF TEMPORARY SUSPENSION

In accordance with the Rules of Procedure Governing Disciplinary Proceedings of the Board of Registration in Medicine, 243 CMR 1.03(11)(a), the Board of Registration in Medicine ("the Board") **ORDERS** that

> The certificate of registration to practice medicine in the Commonwealth of Massachusetts of Eugene C. Jagella, M.D.'s Registration No. 74082, is **SUSPENDED** effective immediately. Eugene C. Jagella, M.D. must cease the practice of medicine immediately, and he is directed to surrender his wallet card and wall certificate to the Board forthwith.

The Board has determined that the health, safety, and welfare of the public necessitate said suspension.

The Respondent shall provide a copy of this Order of Suspension within twenty-four (24) hours to the following designated entities: any in- or out-of-state hospital, nursing home, clinic, other licensed facility, or municipal, state, or federal facility at which he practices medicine; any in- or out-of-state health maintenance organization with whom he has privileges or any other kind of association; any state agency, in- or out-of-state, with which he has a provider contract; any in- or out-of-state medical employer, whether or not he practices medicine there; and the state licensing boards of all states in which he has any kind of license to practice medicine; Drug Enforcement Administration Boston Diversion Group; and the Massachusetts Department of Public Health Drug Control Program. The Respondent is further directed to certify to the Board within forty-eight (48) hours that he has complied with this directive.

[redacted]

Candace Lapidus Sloane, M.D.
Board Chair

Dated: January 25, 2018

SENT CERTIFIED MAIL 1/27/18 (MS)

COMMONWEALTH OF MASSACHUSETTS

Middlesex, SS.

Board of Registration in Medicine

Adjudicatory Case No. 2018-006

In the Matter of

EUGENE C. JAGELLA, M.D.

ORDER OF REFERENCE TO DIVISION OF ADMINISTRATIVE LAW APPEALS

The Board hereby refers the above-captioned matter to the Division of Administrative Law Appeals for recommended Findings of Fact and necessary Conclusions of Law only.

The Board's Complaint Counsel, the Respondent and any intervenor shall file all papers, transcripts, exhibits or other record entries with both the Board of Registration in Medicine at 200 Harvard Mill Square, Suite 330, Wakefield, MA 01880, and also with the Division of Administrative Law Appeals at One Congress Street, 11th Floor, Boston, Massachusetts 02114, in addition to service amongst the Complaint Counsel, the Respondent and any intervenor. Filings for review by the full Board, such as an interlocutory appeal or objections to a Recommended Decision, shall include three (3) copies addressed to the Executive Director and one copy to the General Counsel.

Upon the Complaint Counsel's receipt of any docket entry originating from an Administrative Magistrate, the Complaint Counsel shall file a copy of same with the Board.

Unless confidentiality is waived by the patient, a) nothing in the public record or docket shall contain patient-identifying information, and b) hearings shall be closed to the public during patient testimony, although transcripts without patient-identifying information are public. Motions to impound and to use pseudonyms, and rulings thereon, shall be filed and docketed under appropriate seal.

[redacted]

Candace Lapidus Sloane, M.D.
Board Chair

Dated: January 25, 2018

SENT CERTIFIED MAIL 1/29/18 MS

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COMMONWEALTH OF MASSACHUSETTS

Middlesex, SS.

Board of Registration in Medicine

Adjudicatory Case No.2018-006

In the Matter of

EUGENE C. JAGELLA, M.D.

STATEMENT OF ALLEGATIONS

The Board of Registration in Medicine (Board) has determined that good cause exists to believe the following acts occurred and constitute a violation for which a licensee may be sanctioned by the Board. The Board therefore alleges that Eugene C. Jagella, M.D. (Respondent) has practiced medicine in violation of law, regulations, or good and accepted medical practice as set forth herein. The investigative docket number associated with this order to show cause is Docket No. 17-115.

Biographical Information

1. The Respondent was born on September 23, 1959. He graduated from the Medical College of Pennsylvania. He has been licensed to practice medicine in Massachusetts under certificate number 74082 since 1991. He is board-certified in Internal Medicine. The Respondent's last known affiliations were as Medical Director for St. Camilus Health Center, a rehabilitation/nursing facility in Whitinsville, MA; Medical Director for Maestro VNA and Hospice in Auburn, MA; on the medical staff of Milford Regional Medical Center; and on the faculty of the University of Massachusetts Medical School and the Regis College nurse practitioner training program. In addition, the Respondent's last known affiliation included an independent practice specializing in the care of chronically ill and disabled persons and spending

approximately seventy percent of his professional time making house calls to his patients who are unable to travel.

Factual Allegations

2. In April 2017, the Board received a statutory report from a nurse practitioner working in a pain management practice that the Respondent had provided excessive amounts of pain medications to a 36 year old patient, (Patient F). The report stated that amount of medications exceeded what is recommended for a non-cancer non-hospice patient. As a result, the Board opened an investigation. At the Board's request, the Respondent has provided the medical records of his Patients A through F, which he certified as complete. Along with the medical records, the Respondent also provided the Board with a written summary of the care he provided to Patients A through F.

Patient A

3. Patient A was a 52 year old man when he first visited the Respondent on January 8, 2004.

4. While the Respondent stated in the medical records that he had no medical history for Patient A, he documented that Patient A suffered from chronic back pain, a history of herniated discs, pericarditis, sciatica, and a prior history of alcoholism. The Respondent also documented that Patient A's sister had died of a drug overdose.

5. The Respondent did not document Patient A's prior medications. However, the Respondent stated that he would continue Patient A on Vicodin and prescribed 30 pills and treated Patient A's flu symptoms with Amantadine.

6. In May 2004, the Respondent added Celebrex to Patient A's pain medications. From July 14, 2004 to August 9, 2004, the Respondent also prescribed 30 Percocet every nine to

16 days and then added Soma. For the remainder of 2004 and through 2005, the Respondent increased the number of Percocet pills to 100 per month.

7. Patient A had a lumbar MRI in 2004, which revealed multiple levels of disc protrusion with possible nerve root abutment. In 2004 there was an apparent lack of insurance coverage for surgery. The Respondent does not document revisiting the possibility of surgery in the future.

8. On January 20, 2006, the Respondent referred Patient A for a possible spinal injection and on January 25, 2006, the Respondent referred Patient A to rehabilitation. The Respondent's records do not document whether Patient A followed up on the Respondent's referrals.

9. In November 2006, the Respondent added Klonopin. On January 10, 2008, the Respondent ordered an MRI for Patient A without documenting a rationale. The Respondent increased Patient A's Percocet to 150 pills per month and by June 2008, the Respondent increased Patient A's Percocet to 200 pills per month without documenting a rationale.

10. On October 19, 2008, the Respondent saw Patient A and documented that his back pain continued and radiated down his legs with weakness and spasms and numbness in the anterior thighs. The Respondent documented that the MS Contin he prescribed for Patient A on October 15, 2008 caused dizziness and that Patient A had refused OxyContin. The Respondent continued to prescribe 200 pills a month of Percocet 7.5 mg.

11. In response to Patient A's continued severe neck and back pain, the Respondent prescribed increasing doses of Oxycodone, with maximum doses by 2017 of 800 pills of 15 mg per month.

12. From 2013 on, Patient A developed a kidney stone, BPH (an enlarged prostate) with urinary retention requiring a Foley catheter, hypertension and lower extremity edema.

13. The Respondent's Prescription Monitoring Program printout showed that the Respondent also prescribed 90 pills a month of EB Lorazepam for Patient A from 2014 to 2017, though he did not document this in his notes.

14. On several occasions the Respondent started a narcotic medication or increased the dose without a face-to-face visit with Patient A and without documentation other than an entry into a medication list.

15. The Respondent's medical records do not document evidence of regular random drug screens for illicit or non-prescribed drugs or a Narcotics Agreement.

16. The Respondent's care of Patient A fell below the standard of care because he:

a. Failed to obtain and review Patient A's prior medical records before prescribing medications to him;

b. Began Patient A on chronic narcotic treatment despite Patient A's history of alcohol abuse and his family history of opiate abuse;

c. Began Patient A on chronic narcotic treatment for radicular neck and back pain despite the possibility of alternatives like injections or surgery;

d. Increased or started new narcotic medications without a face-to-face visit and with insufficient documentation;

e. Increased narcotic doses beyond the point of efficacy and likely causing side effects like tolerance, hyperalgesia, and/or urinary retention problems;

f. Prescribed Lorazepam without any documentation of the diagnosis, discussion of treatment options, or why other agents like SSRIs were not considered;

g. Failed to document Patient A's medical records appropriately; and

h. Failed to document regular random drug screens and a Narcotics Agreement.

Patient B

17. Patient B was a 52 year old man when he first sought treatment with the Respondent on June 14, 2016. At that visit, the Respondent diagnosed Patient B with chronic back pain, shoulder pain, anxiety, and depression.

18. While the Respondent documented a plan to get Patient B's past medical records related to the back and shoulder pain, no such documents are in the medical records. While the Respondent documented a plan to continue Patient B's previous psychiatric medications, there is no documentation in his notes as to what they were.

19. According to the Respondent's Prescription Monitoring Program printout, Patient B had previously been prescribed monthly 30 pills of Oxycodone 5 mg, 90 pills of Diazepam 5 mg, and 90 pills of Xanax 1 mg. When the Respondent took over Patient B's care, he increased Patient B's to 200 pills of Oxycodone 15 mg (an increase of Oxycodone from 5 mg per day to 100 mg per day) and continued the 90 pills of Xanax 1 mg for anxiety.

20. In July, August, and September 2016, the Respondent increased Patient B's OxyContin to 30 mg, 40 mg, and 60 mg respectively. The July and August 2016 medication increases were based on phone calls rather than face-to-face visits.

21. Patient B had surgery in November 2016, but continued to have significant pain, including pain from a wound abscess.

22. By January 2017, when the surgeon prescribed Neurontin to Patient B, the Respondent increased Patient B's OxyContin to 80 mg twice a day, but had to cut the frequency

to once a day, to address Patient B's sedation from the medication. In addition, the Respondent was still prescribing Xanax and Diazepam.

23. By May 2017, the Respondent weaned Patient B's OxyContin prescription down to 20 mg twice a day plus 230 pills a month of 10 mg of Oxycodone.

24. While the Respondent's medical records include a narcotics agreement for Patient B, the records do not document evidence of regular random drug screens for illicit or non-prescribed drugs.

25. The Respondent's care of Patient B fell below the standard of care because he:

a. Failed to obtain and review Patient B's prior medical records before prescribing medications to him;

b. Managed Patient B's anxiety and depression with Xanax without considering other options, like SSRIs or NSRIs;

c. Prescribed high and increasing doses of narcotics for Patient B's pain without establishing a clear benefit and despite the apparent harm of sedation, tolerance, and possible hyperalgesia;

d. Failed to adequately document Patient B's medical records; and

e. Failed to document regular random drug screens.

Patient C

26. Patient C was a 31 year old man when he first saw the Respondent on May 28, 2004 for a hospital admission for chest pain. Patient C had been diagnosed with significant mental health problems and he was an active intravenous heroin user.

27. When the Respondent saw Patient C again on June 2, 2004, as an outpatient, his plan was to treat Patient C with OxyContin "for pain control and to keep Patient C off of heroin."

The Respondent also diagnosed Patient C with chronic headaches, for which he prescribed Fiorinal with codeine.

28. The Respondent would end up treating Patient C, with periodic lapses in care, until April 2017, during which time Patient C had at least ten drug and/or psychiatric related hospital admissions and several incarcerations for drug offenses, despite participating in several detox programs.

29. From June to December 2004, among the drugs which the Respondent prescribed for Patient C were Oxycodone, MS Contin, Xanax, Darvon, Hydrocodone/APAP and Fiorinal with codeine.

30. On June 11, 2004, at Patient C's request, the Respondent switched Patient C from OxyContin to MS Contin. On June 21, 2004, the Respondent noted that Patient C had stated that his MS Contin was stolen.

31. On June 30, 2004, the Respondent noted that Patient C had been discharged from a drug detox program four days prior and had admitted to active heroin use. The Respondent referred Patient C to counseling.

32. On August 20, 2004, Patient C was in the ER for an apparent narcotic overdose.

33. On September 9, 2004, the Respondent documented a phone call with the police, who told him that Patient C had been arrested for narcotic possession and distribution. The Respondent documented that Patient C denied the allegation and the Respondent prescribed Patient C Xanax and advised counseling.

34. On September 14, 2004, the Respondent prescribed Darvon to treat narcotic withdrawal symptoms and on September 28, 2004 documented that Darvon would be discontinued when Patient C "gets into the methadone clinic."

35. On October 10, 2004, despite a Suboxone prescription for Patient C from another physician treating him for opiate dependence, the Respondent continued to prescribe Hydrocodone/APAP and Fiorinal with codeine to Patient C.

36. On November 8, 2004, Patient C told the Respondent that he would be going to jail for sixty days and could take his medications with him. On November 11, 2004, the Respondent prescribed 120 tablets a month of Oxycodone to Patient C at his request. The Respondent prescribed another 30 pills of Oxycodone on December 7, 2004. On December 11, 2004, Patient C was admitted to the hospital for rhabdomyolysis related to his heroin use. Three days later, on December 15, 2004, the Respondent prescribed more Oxycodone to Patient C, noting that there was an understanding that Patient C would not take heroin while on Oxycodone.

37. In 2005, Patient C was imprisoned for drug charges and the Respondent added Dilaudid and methadone to Patient C's prescriptions, upon his release.

38. On May 10, 2005, the Respondent treated Patient C for a forearm abscess caused by self-injection infection. In December 2011 Patient C said that he accidentally stuck himself with a dirty needle.

39. In 2006, the Respondent prescribed Percocet, and then at Patient C's request, he switched Patient C to fentanyl. Patient C was incarcerated in 2006 and within days of his release he relapsed, overdosed, and was admitted to the hospital for chest pain. Later in December 2006, Patient C was admitted to the hospital for a fentanyl overdose.

40. In 2007, the Respondent prescribed methadone to Patient C to treat his pain, while Patient C was in treatment at a methadone clinic.

41. On February 8, 2008, Patient C was admitted to the hospital after being found unresponsive. When the Respondent saw Patient C in follow-up, the Respondent prescribed methadone.

42. On April 12, 2008, the Respondent saw Patient C after he had been admitted for a psychiatric hospitalization associated with ethylene glycol poisoning. The Respondent noted Patient C's history of polysubstance abuse and chronic back pain and planned to continue prescribing a low dose of methadone. On July 8, 2008, at Patient C's request, the Respondent prescribed Serax for anxiety.

43. On July 11, 2009, Patient C reported that he was living in a halfway house for drug detoxification/rehabilitation, was diagnosed with bipolar disorder, and was doing better off of narcotics.

44. On January 24, 2010, due to neck pain after a motor vehicle accident where Patient C hit a telephone pole, the Respondent prescribed Ultram and added Adderall. Two months later, after another motor vehicle accident where Patient C had a positive blood alcohol level and urine positive for cocaine and THC, the Respondent recommended watching for more drug and alcohol abuse. One month later, when Patient C admitted to taking double the prescribed amount of Ambien, the Respondent told Patient C not to do that.

45. Continuing from 2010 to 2017, the Respondent continued his practice of prescribing narcotics and benzodiazepines to Patient C despite his insufficient documentation to justify his practices and despite Patient C's continued hospitalizations related to his drug use or for his psychiatric illnesses, including suicidal ideation.

46. The Respondent's medical records for Patient C do not document a Narcotics Agreement, however there are nine drug screens noted in the Respondent's medical record for Patient C, of which the Respondent is the ordering physician on six screens.

a. On May 28, 2004 another medical provider ordered a drug screen which was only positive for opiates.

b. On January 13, 2005 the Respondent ordered a drug screen which was positive for amphetamines, barbiturates, benzodiazepines and opiates.

c. On January 21, 2005 the Respondent ordered a drug screen which was positive for amphetamines, barbiturates, benzodiazepines and opiates.

d. On February 3, 2005 the Respondent ordered a drug screen which was positive for barbiturates, benzodiazepines and opiates.

e. On December 7, 2006 the Respondent ordered a drug screen which was positive for amphetamines and benzodiazepines.

f. On March 12, 2010 another medical provider ordered a drug screen which was positive for amphetamines, benzodiazepines, cocaine and THC.

g. On February 1, 2012 the Respondent ordered a drug screen which was positive for amphetamines and benzodiazepines.

h. On April 30, 2013 another medical provider ordered a drug screen which was only positive for benzodiazepines.

i. On June 28, 2012 the Respondent ordered a drug screen which was positive for benzodiazepines and opiates.

47. The Respondent's medical records for Patient C do not clearly indicate any follow-up with the patient regarding the results of these drug screens.

48. The Respondent's care of Patient C fell below the standard of care because he:

a. Engaged in a lengthy pattern of prescribing narcotics to a patient with a clear history of active polysubstance abuse, who had multiple hospitalizations for serious consequences related to the abuse;

b. Failed to recognize the clearest contraindication to chronic narcotic therapy, which is active opiate addiction;

c. Ignored Patient C's repeated obvious signs of opioid abuse, including active heroin use, an abscessed self-injection site, overuse of the narcotic medications prescribed, lost or stolen prescriptions, drug seeking behavior, significant overdoses, legal problems/arrests, bloody needle stick injury, motor vehicle accidents with illicit substances in the urine, verbalization of intent to use heroin if he was not prescribed a narcotic, and multiple requests for controlled substance prescriptions;

d. Restarted narcotic and benzodiazepine medications after a lapse of care;

e. Supplemented methadone while Patient C was in active treatment in a methadone clinic;

f. Provided insufficient documentation for prescribing practices;

g. Failed to insist that Patient C seek treatment from an addiction specialist; and

h. Failed to document a Narcotics Agreement.

Patient D

49. Patient D was a 64 year old woman when she first saw the Respondent on January 27, 2016. Among Patient D's medical problems was chronic back pain, for which she had been

treated with methadone for 30 years. However, the methadone was no longer controlling Patient D's pain.

50. The Respondent continued to prescribe 50 mg of methadone, plus increasing amounts of Oxycodone for Patient D from January to May 2016, when Patient D was getting 100 pills of 15 mg of Oxycodone.

51. By June 26, 2017, the Respondent reported that Patient D continued to have breakthrough pain and that he would taper down her methadone prescription as he increased her Oxycodone. However, the Respondent did not do so and kept Patient D's methadone dose at 50 mg per day, while he continued to increase her dosage of Oxycodone.

52. In September 2016, Patient D went to the ER due to sedation.

53. In October 2016, the Respondent increased the Oxycodone to 120 pills per month of 20 mg and then in March 2017, increased the number of pills to 140 per month, while continuing Patient D on her methadone.

54. In March 2017, Patient D experienced vomiting and shortness of breath for which the Respondent recommended an ER evaluation. The Respondent refilled Patient D's methadone, but recommended stopping the Oxycodone, as he believed she should not be taking both.

55. In April 2017, the Respondent increased Patient D's methadone dose from 50 mg to 80 mg and then 100 mg per day, due to her inadequate pain relief.

56. On May 17, 2017, the Respondent noted that Patient D was willing to slowly taper off of her methadone medication, as it was ineffective, and restart Oxycodone. The last methadone prescription was decreased to 40 mg per day, with the re-addition of 140 pills of Oxycodone at 20 mg per day.

57. The Respondent's medical records do not document evidence of regular random drug screens for illicit or non-prescribed drugs or a Narcotics Agreement.

58. The Respondent's care of Patient D fell below the standard of care because he:

a. Exposed Patient D to significant risks, like constipation, tolerance, and sedation, by increasing Patient D's doses of methadone and Oxycodone significantly and without benefit;

b. Failed to explore other avenues of treatment once increased doses of narcotics to Patient D were inadequate;

c. Failed to increase Patient D's methadone doses slowly, with caution to avoid sedation;

d. Failed to follow his own prescribing recommendation to reduce the medication dosage; and

e. Failed to document regular random drug screens and a Narcotics Agreement.

Patient E

59. The Respondent first saw Patient E, a 33 year old man, on August 15, 2006. Patient E complained of knee, arm, and ankle pain, was diagnosed with hypertension, and suffered from ingrown hair follicles, chronic cholecystitis, kidney stones, cigarette abuse, and morbid obesity.

60. The Respondent's medical records for Patient E do not include prior medical records or make clear Patient E's prior prescriptions.

61. The Respondent prescribed the following medications to Patient E at his initial August 15, 2006 visit:

a. Atenolol;

b. Avalide for hypertension; and

c. Percocet, 150 pills.

62. Two weeks later, on September 1, 2006, the Respondent prescribed 100 tablets of Percocet and then two weeks after that, on September 16, 2016, the Respondent prescribed 100 additional tablets.

63. At Patient E's next visit on October 16, 2007, the Respondent, at Patient E's request, prescribed 50 Vicodin pills per month and 50 Valium pills per month, without documenting a physical exam.

64. The Respondent had no face-to-face contact with Patient E after October 16, 2007 until December 9, 2009. However, during this time the Respondent issued continuous prescriptions for Vicodin and Valium, increasing Patient E's Vicodin to 75 and then 100 pills per month and his Valium to 90 pills per month, without documenting a rationale.

65. Patient E suffered a myocardial infarction in March 2012 and was followed by cardiology. In January 2013, Patient E was admitted to the hospital for unstable angina.

66. On May 21, 2012 and June 28, 2012, the Respondent requested that Patient E submit to a urine drug screen. One drug screen was performed, on June 28, 2012, which was positive for benzodiazepines and opiates.

67. On September 27, 2012, Patient E complained of worsening knee, dental, and back pain and requested Oxycodone in addition to the Percocet. The Respondent continued prescribing the 360 pills of Percocet, 10 mg and added Oxycodone 10 mg, initially 20-30 pills per month and then up to 60 pills per month by 2013.

68. On February 18, 2013, the Respondent noted that Patient E tried to fill his Oxycodone prescription at CVS, which was a violation of his narcotic agreement. The Respondent documents no discussion of a plan to address this occurrence.

69. On November 24, 2013, the Respondent noted that Patient E had been seen at the ER multiple times for panic symptoms, which were not well controlled with the 100 Valium pills per month. The Respondent added 90 pills per month of Ativan, 1 mg.

70. On February 26, 2014, the Respondent requested Patient E see a pain specialist, however there is no documentation to indicate whether Patient E did so.

71. On January 24, 2015, when Patient E ran out of Percocet and Valium, the Respondent documented probable withdrawal symptoms for which he prescribed Oxycodone.

72. On August 2, 2016, the Respondent documented that Patient E continued to be in a great deal of pain, despite the narcotic prescriptions, but the Respondent believed that Patient E needed to stay on the narcotics or his pain would be worse.

73. On December 31, 2016, Patient E reported headaches, which he believed to be due to his hypertension; his blood pressure was 160/100. Patient E requested Fioricet and the Respondent prescribed it. By this time the Respondent was prescribing the following to Patient E monthly:

a. Fioricet;

b. Percocet 10 mg/325 mg, 300 pills;

c. Oxycodone 15 mg, 100 pills (150 mg Oxycodone daily);

d. Ativan 2 mg, 90 pills; and

e. Valium 10 mg, 100 pills.

74. While the Respondent's medical records for Patient E contain Narcotics Agreements, they do not contain documentation of regular random drug screens for illicit or non-prescribed drugs.

75. The Respondent's care of Patient E fell below the standard of care because he:

a. Failed to obtain and review Patient E's prior medical records before prescribing medications to him;

b. Increased Patient E's narcotic and benzodiazepine doses over time without clear benefit;

c. Allowed Patient E to develop a tolerance and dependence on the medications without a clear benefit;

d. Failed to offer Patient E first line therapy for anxiety and panic, such as an SSRI or SNRI instead of or combined with small doses of benzodiazepines; and

e. Failed to conduct regular drug screens to check for diversion and or the use of other addictive substances.

Patient F

76. Patient F was a 31 year old woman at the time of her first visit with the Respondent on September 7, 2011.

77. The Respondent did not have Patient F's previous medical records, but documented that Patient F was on methadone and oxycodone for chronic pain due to a prior motor vehicle accident.

78. From September 2011 to December 2011, the Respondent prescribed the following medications for Patient F:

f. Methadone 60 mg twice a day;

g. Oxycodone 20 mg. 150 pills per month;

h. Clonazepam 2 mg. 210 pills per month;

i. Carisoprodol (Soma);

j. clonidine; and

k. promethazine.

79. When the Respondent next saw Patient F, on December 4, 2012, he documented that Patient F had been incarcerated for six months "for driver's license/probation and not for drug charges." The Respondent stated in her medical record that while Patient F was incarcerated she was kept on medications which he had prescribed to her and also prescribed Neurontin 800 mg three times a day, Adderall 20 mg three times a day, Prozac, and Prilosec. The Respondent also stated that he wanted to verify why she was on Neurontin and Adderall, but there is no documentation that he did so.

80. In December 2012 and February 2013, the Respondent prescribed all of the previous medications he had prescribed for Patient F plus the new medications, Neurontin and Adderall. The Respondent also increased Patient F's Oxycodone from 20 mg to 30 mg.

81. In August 2013, the Respondent saw Patient F, at which time he documented that she had been hospitalized and in a rehabilitation facility after being assaulted by her husband. Upon review of the discharge papers, the Respondent documented that Patient F had been prescribed methadone and Dilaudid for severe pain, in addition to Adderall, Ativan, Ambien, and Seroquel. The Respondent continued these medications, prescribing 30 mg of methadone twice a day and 2 mg of Dilaudid, 400 pills a month.

82. On September 20, 2013, the Respondent signed off on a Visiting Nurse Association certification, which indicated that Patient F had a history of opioid abuse.

83. On December 6, 2013, the Respondent increased Patient F's Neurontin dose.

84. On February 7, 2014, the Respondent ordered a urine drug screen and received the results on March 9, 2014. The drug screen results were negative for benzodiazepines, cocaine, amphetamines, THC, opiates, and barbiturates, despite the benzodiazepine (Ativan) and opiates that he was prescribing to Patient F. The Respondent's notes provide no discussion about why this occurred.

85. Around the time of the drug screen, the Respondent switched Patient F from Dilaudid back to Oxycodone and continued prescribing the methadone, Ativan, and other medications to her.

86. On October 14, 2016, the Respondent noted that he was concerned that Patient F was getting excessive doses of pain medications and needed to see a pain specialist. However, the Respondent continued to prescribe the same amount of pain medications for the next several months.

87. When the Respondent received a copy of a March 31, 2017 Sturdy Memorial Hospital pain management assessment, which recommended that Patient F be tapered off of her pain medication due to lack of efficacy, excessive doses, and the development of hyperalgesia, both he and Patient F rejected the assessment. While continuing to prescribe the same amount of pain medication, the Respondent sought a second opinion, in May 2017, from Massachusetts General Hospital. The Respondent's medical records show no pain assessment from Massachusetts General Hospital.

88. Despite signing off on the Visiting Nurse Association certification in September 2013, which documented Patient F's history of opioid abuse, on March 13, 2017, the Respondent documented that he noticed for the first time that the past record from Patient F's rehabilitation

facility had documented Patient F's intravenous drug abuse. When the Respondent asked Patient F about her intravenous drug use, she denied it and the Respondent said that he would expunge it from her record.

89. In or around April 2017, the Respondent learned that Patient F had been using a pharmacy in Rhode Island, requesting early refills and overusing her Oxycodone.

90. The Respondent's medical records for Patient F do not document a Narcotics Agreement.

91. The Respondent's care of Patient F fell below the standard of care because he:

a. Failed to recognize Patient F's signs of possible opiate abuse disorder and act upon it;

b. Failed to recognize Patient F's signs of possible complications of chronic opioid use, including hyperalgesia;

c. Failed to obtain corroboration of Patient F's statements, including documentation of her motor vehicle accident and previous medical diagnoses;

d. Failed to obtain Patient F's past medical records before prescribing chronic pain medication;

e. Failed to react in a timely manner to Patient F's documented opioid abuse and then when he reacted over two and half years later, he dismissed the diagnosis, based solely on Patient F's denial;

f. Failed to screen Patient F regularly for illicit or non-prescribed drug use or to verify that she was taking her prescribed medications;

g. Failed to respond to Patient F's troubling drug screen results when he did do a drug screen;

h. Failed to respond appropriately to Patient F's reported six month incarceration;

i. Failed to seek verification when Patient F made the unusual statement that she had been able to continue her medications in jail, with the addition of Neurontin and Adderall;

j. Failed to act upon the advice of a pain management specialist assessment which suggested that Patient might be developing hyperalgesia due to his narcotic prescribing, and instead continued to prescribe high doses of narcotics;

k. Failed to respond appropriately to Patient F's likely attempts to manipulate him; and

l. Failed to document a Narcotics Agreement.

Legal Basis for Proposed Relief

A. Pursuant to G.L. c. 112, §5, eighth par. (c) and 243 CMR 1.03(5)(a)3, the Board may discipline a physician upon proof satisfactory to a majority of the Board, that he engaged in conduct that places into question the Respondent's competence to practice medicine, including but not limited to gross misconduct in the practice of medicine, or practicing medicine fraudulently, or beyond its authorized scope, or with gross incompetence, or with gross negligence on a particular occasion or negligence on repeated occasions.

B. Pursuant to *Levy v Board of Registration in Medicine*, 378 Mass. 519 (1979); and *Raymond v Board of Registration in Medicine*, 387 Mass. 708 (1982), the Board may discipline a physician upon proof satisfactory to a majority of the Board, that said physician has engaged in conduct that undermines the public confidence in the integrity of the medical profession.

C. Pursuant to G.L. c. 112, §5, eighth par. (h) and 243 CMR 1.03(5)(a)11. the Board may discipline a physician upon proof satisfactory to a majority of the Board, that said physician has violated of a rule or regulation of the Board. Specifically:

1. 243 CMR 2.07(13)(a), which requires a physician to:

a. maintain a medical record for each patient, which is adequate to enable the licensee to provide proper diagnosis and treatment

The Board has jurisdiction over this matter pursuant to G.L. c. 112, §§ 5, 61 and 62. This adjudicatory proceeding will be conducted in accordance with the provisions of G.L. c. 30A and 801 CMR 1.01.

Nature of Relief Sought

The Board is authorized and empowered to order appropriate disciplinary action, which may include revocation or suspension of the Respondent's license to practice medicine. The Board may also order, in addition to or instead of revocation or suspension, one or more of the following: admonishment, censure, reprimand, fine, the performance of uncompensated public service, a course of education or training or other restrictions upon the Respondent's practice of medicine.

Order

Wherefore, it is hereby ORDERED that the Respondent show cause why the Board should not discipline the Respondent for the conduct described herein.

By the Board of Registration in Medicine,

[redacted]

Candace Lapidus Sloane, M.D.
Board Chair

Date: January 25, 2018

SENT CERTIFIED MAIL. 1/27/18